Application Checklist

(Medical)

Complete and return this form as part of your application packet.

APPLICANT	DDDS USE ONLY
Applicant Name: (please print)	Evaluator's Name: (please print)
Contractor Intake Form	Contractor Intake Form
Copy of Washington State Master Business License (UBI)	Copy of Washington State Master Business License (UBI)
Applicant Certification and Assurances Form	Applicant Certification and Assurances Form
Copy of Certificates of Insurance Professional Liability General Liability (DSHS as Certificate Holder*)	 Copy of Certificates of Insurance □ Professional Liability □ General Liability (DSHS as Certificate Holder*)
Acknowledgment of Professional Qualification and Confidentiality Form	Acknowledgment of Professional Qualification and Confidentiality Form
Statement of Agreement for Medical Providers	Statement of Agreement for Medical Providers
Copy of Washington State Professional or Medical License	Copy of Washington State Professional or Medical License
Curriculum Vitae or Resume	Curriculum Vitae or Resume
W-9 & SWV Form ** DO NOT include this form in your application packet **	
Signature Date	Evaluator's initials Date

^{*} DSHS Enterprise Risk Management Office, Insurance Services, PO Box 45882, Olympia, WA 98504-5882